Montana Medicaid Claim Jumper

Top Ten Prior Authorization Denials for Medical Equipment and Supplies

1. **Documentation does not support medical necessity.** Evaluations are not complete regarding diagnosis, current functions and goals. List all trials/uses and outcomes of such.
2. **Documentation has conflicting information.** Supporting information does not coincide among those involved with the individual. Current documentation conflicts with earlier requests regarding the individual's condition or need without reason.
3. **Documentation is not complete.** Make sure that the minimum required documentation, at the very least, is included in your packet. Double check documents and forms for completeness to include appropriate signatures and dates.
4. **Patient is not eligible for Medicaid.** Check eligibility before sending in the request. Some individuals must pay a portion of their medical expenses before they are eligible for Medicaid. If this is the case, make sure to point that out to the reviewer.
5. **Items/services were not reviewed prior to delivery**. Requests will be denied if the item was delivered prior to being reviewed if required of such items/services by the Department.
6. **CMN not appropriate for the item/service to be reviewed.** Make sure that the required documentation is included in your packet.
7. **Review is being requested solely for a denial to receive payment from other source.** Provide non-coverage information available from the Department, i.e. provider manual, notices, newsletters, etc. to requesting payers.
8. **Inappropriate coding.** Research current publications of level II code books for appropriate coding. If a provider is unable to decide on the proper code for a covered item, contact the manufacturer or distributor of the item for coding guidance. Once the appropriate code is determined, review the current program manual and fee schedule for special coverage instructions.
9. **Requester is not authorized to provide service.** Authorization from the Department is specific to the provider delivering the item/service. Reimbursement can only be provided to enrolled providers authorized to provide that item/service.
10. **Place of service causing denial of claims.** Medicaid provider manuals, bulletins/notices, administrative rules are the best guidelines for covered services.

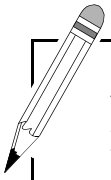
Global Surgery Edit

The Global Surgery Edit has recently been reevaluated. We, like Medicare and other payers, require the use of CPT modifiers when billing certain surgical and/or E&M codes within the specific time period of another surgical code. The claims system has been updated to closely review the use of modifiers for claims involving the global surgery period. Inappropriate use of modifiers will result in denied claims. This edit is effective July 19, 2002.

The global surgery period affects providers who are in the same group practice (providers billing under the same tax ID number) **AND** who have the same specialty. These providers may not bill services related to the surgery performed during the time span designated for that code in the fee schedule.

When the value for a procedure is set, it includes the cost of the operation, a pre-op visit (after the decision for surgery has been made), routine follow-up, post-surgical pain management and post-operative complications that do NOT require another trip to the operating room. Please refer to the Provider Notice dated March 20, 2000 for further definitions of time spans and covered services related to global surgery. For current global surgery information, refer to the current Medicaid fee schedule for your provider type. The

new *Physician Related Services* manual located on the Provider Information Web Site also has global surgery information and examples. Please refer to your CPT 2002 book when you have coding questions.



Reminder: Modifier 24 is for unrelated E&M services by the same provider during a post-operative period; modifier 25 is for significant, separate E&M services by the same provider on the same date of procedure. When splitting the global package, use modifiers 54 and 55, and modifier 57 is for decision for surgery.

Provider Information Web Site

If you have not yet visited the Provider Information Web Site, please take a few minutes to look over the materials available. The site has current fee schedules (in Adobe and Excel formats), previous fee schedules, current manuals, newsletters, forms, and more. The section containing notices and manual replacement pages is currently under construction and will be available soon. All you need to get this information is Internet access and Adobe Reader. The Provider Information web site has links to Adobe for downloading Adobe Reader. There are several advantages to obtaining information on line:

- Anyone with Internet access can view the information on line or download the files to their own computer.
- For those who don't have Internet access, the files can be downloaded by someone with access and shared with others on a network or by copying it to diskette and passing it along.
- Information is easy to find. Provider manuals and fee schedules are in alphabetical order by provider type. The larger files, like *Frequently Asked Questions* (located under the *Forms and FAQs* option), are "bookmarked" to allow readers to quickly find the topic they are looking for.
- When changes are made to a Medicaid program, the replacement pages and updated manual are available almost immediately. Providers can delete their old version and save the new version, or they can print only the replacement pages to insert into their manual binder.
- Providers can print entire manuals and spreadsheets or only those pages or sections they need.
- Information can be copied from the online version of the manuals and fee schedules and pasted into other documents such as office guidelines.
- Providers can print as many paper copies as they want from the Internet site and distribute them to everyone who needs a copy.

Please go to www.dphhs.state.mt.us/hpsd and select *Medicaid* followed by *Provider Information*. If you do not find the information you are looking for on this site, please E-mail the web master. We want to keep this web site as useful and up-to-date as possible.

TPL Tips

Please note that all local Z codes no longer need the blanket denial attachment to be forced for TPL. This is a recent change to our system, and is ONLY true of local Z codes. All other codes that are typically not paid by another insurance must STILL have a blanket denial attached.

Blanket denials from either our TPL office or other insurance companies are only valid for 2 years. When these denials expire, you must either contact TPL to be issued a new denial or rebill the other insurance company to get a new denial for services.

If you currently use a blanket denial for diapers, please be aware that you will need to get a new denial from TPL or the primary insurance company because the Montana Medicaid procedure code has changed.

Please be certain to send in the explanation of any denial codes included on the EOB from other payers. We cannot accept EOB's without that explanation for the denial codes, and these claims will be denied.

If you are having problems with a claim, and would like the TPL office to review it, please send the claim to them at: TPL, P.O. Box 5838, Helena MT 59604.

Emergency Rule Changes

There have been recent emergency revisions to the Administrative Rules of Montana (ARM) in regards to budget cuts for state fiscal year 2003 that are part of the Department's 3.5% cost reduction plan development directed by the Governor's office. The changes are in connection with anticipated state surplus falling below a stipulated level according to 17-7-140 MCA. Interested parties can review emergency rule revisions, proposed rule changes, and ver-

ify dates of public hearings on the Department web site at http://www.dphhs.state.mt.us. Click on "Legal" and then "Department Montana Administraive Register (MAR) Notices".

Modifier Tips

- When billing with modifier 50 for bilateral services, put all information on one line with one unit. You do not need to use modifiers for left and right, and do not bill on separate lines. For example, a bilateral carpal tunnel surgery would be billed like this:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS
08	23	02	08	23	02	22	0	64721	50	1	800 00	1

- Check the fee schedule to see if Medicaid allows the use of the following modifiers for a particular code: bilateral (50), multiple procedures (51), co-surgery (62), assistant at surgery (80, 81, 82, AS), and team surgery (66).

Modifier Changes as of 07/01/02

As of dates of service 07/01/02 forward, the modifier AN will no longer be valid for Medicaid. Hence, mid-level practitioners will be required to bill under their own provider number, beginning 07/01/02. The AN modifier was turned off by Medicare in 1999. Previously, Medicaid had continued to allow mid-level practitioners to bill their services under the provider number of their employing physician with the modifier AN. After 07/01/02, if a provider bills a service with their physician provider number, using the modifiers AN, SA or AS to indicate a mid-level practitioner's service, the mid-level's service will deny.

From 07/01/02 forward, mid-level practitioners will bill services completely under their own Medicaid provider number. mid-level practitioners can use the modifier AS if assisting a physician in surgery, or SA if they are a nurse practitioner rendering a service in collaboration with a physician. These changes will bring Medicaid's mid-level practitioner policy in line with Medicare's policy. This will also facilitate payment of claims for mid-level practitioners.

Recent Publications

The following publications have been sent out since 04/01/02. Should you desire a copy of any of these notices, please contact ACS Provider Relations at (800) 624-3958 or (406) 442-1837 in Helena and outside of the state of Montana.

- CPT-4 Coding Changes as of 01/01/02 – sent to HCFA-1500 Billers (Podiatrists, Ambulatory Surgical Centers, Physicians, Case Management, Lab & X-ray, Mid-level Practitioners, Public Health Clinics)
- Physician Fee Schedule, VFC changes and Modifier changes as of 07/01/02 – sent to CMS-1500 Billers (Podiatrists, Ambulatory Surgical Centers, Physicians, Case Management, Lab & X-ray, Mid-level Practitioners, Public Health Clinics)
- Emergency Rule Notification for 2.6% Reduction on Allowed Amount as of 07/01/02 – sent to Physicians, Mid-level Practitioners, Podiatrists, Physical Therapists, Occupational Therapists, Speech Therapists, Audiologists, Optometrists, Opticians, Providers of Clinic Services, EPSDT Providers, Independent Diagnostic Testing Facilities, Imaging, Oral Surgeons, Ambulatory Surgical Centers, Inpatient Hospitals, Outpatient Hospitals, Dental Providers, Denturists, Durable Medical Equipment Providers, Commercial Transportation and Specialized Non-Emergency Transportation Providers and Ambulance Providers
- PASSPORT Approval for Cardiography & Echocardiography Codes – 07/01/02 – sent out to Physicians and Mid-level Practitioners
- PASSPORT 24-Hour Availability – 06/07/02 – sent out to all providers

Provider Information Web Site Update

www.dphhs.state.mt.us/hpsd

- July 2002 fee schedules in PDF and Excel formats
- July 2002 Physician Related Services Manual
- June 2002 Pharmacy manual update
- July 2002 Dental and Denturist manual update
- July 2002 Drug Prior Authorization Update

Montana Medicaid
ACS
P.O. Box 8000
Helena, MT 59604

Key Contacts

Provider Relations (800) 624-3958 Montana
(406) 442-1837 Helena and out-of-state
(406) 442-4402 fax

FAXBACK (800) 714-0075

Automated Voice Response (800) 714-0060

Point-of-sale help desk (800) 365-4944

PASSPORT (800) 480-6823

Direct Deposit (406) 444-5283

Prior Authorization:

DMEOPS(406) 444-0190
Mountain-Pacific Quality Healthcare Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7951